

## **Summary of Public Input Process – DRAFT – June 19, 2002**

### **Introduction**

Massachusetts has a long and rich tradition of involved citizen debate in policy discussions and State/local concerns. Citizen involvement is also important to the LECG team and has been used successfully in other consulting assignments. For this project to produce a product that is not only acceptable to the people of Massachusetts but also implementable, the opinions of health care stakeholders and other citizens were a crucial component.

Public input was solicited through three means:

1. Stakeholder interviews
2. Public forums
3. Consumer survey

From December 13, 2001 through March 19, 2002, we interviewed a total of 118 health care stakeholders regarding the current state of health care financing and delivery in Massachusetts, and their thoughts on how the system might be improved. These individuals represented the Massachusetts Legislature, state government, health care insurers, hospitals and other health care providers, associations, foundations, advocacy groups, labor unions, academia, and other companies and organizations. The organizations and agencies included:

#### State Government

- Commonwealth of Massachusetts, Executive Office of Health and Human Services
- Department of Mental Health
- Department of Public Health
- Division of Health Care Finance and Policy
- Division of Insurance
- Group Insurance Commission
- House of Representatives and Senate, Commonwealth of Massachusetts

#### Health Care Insurers

- Aetna US Healthcare
- Blue Cross Blue Shield of Massachusetts
- Fallon Community Health Plan
- Harvard Pilgrim Health Care, Inc.
- Health New England, Inc.
- Neighborhood Health Plan

- The Chickering Group
- Tufts Health Plan

#### Hospitals and Other Health Care Providers

- Boston Medical Center
- Cambridge Health Alliance
- Cooley Dickinson Physician Hospital Organization
- Health Care for the Homeless
- Holyoke Hospital
- Springfield Southwest Community Health Center, Inc.

#### Associations, Foundations, Advocacy Groups, and Unions

- Ad Hoc Committee to Defend Health Care
- Associated Industries of Massachusetts
- Blue Cross Blue Shield of Massachusetts Foundation
- Greater Boston Chamber of Commerce
- Health Care for All
- Home Health Care Association of Massachusetts, Inc.
- League of Women Voters
- Lighthouse Health Access Alliance
- Massachusetts AFL-CIO
- Massachusetts Association for Mental Health, Inc.
- Massachusetts Association of Health Plans
- Massachusetts Biotechnology Council
- Massachusetts Business Association
- Massachusetts Council of Churches
- Massachusetts Extended Care Federation
- Massachusetts Hospital Association
- Massachusetts Law Reform
- Massachusetts League of Community Health Centers
- Massachusetts Medical Society
- Massachusetts Nurses Association
- Massachusetts Senior Action Council
- Mass Care
- Mental Health and Substance Abuse Corporations of Massachusetts, Inc.
- National Federation of Independent Businesses
- Service Employees International Union, Local 285
- Universal Health Care Education Fund

#### Academia

- Boston University School of Public Health
- Brandeis University, Heller School for Social Policy and Management

- Harvard Medical School, Department of Social Medicine

#### Other Companies/Organizations

- Analog Devices, Inc.
- Foley Hoag, Attorneys at Law
- Massachusetts Healthcare Purchaser Group
- Raytheon Company
- Small Business Service Bureau, Inc.

A complete list of interviewees is included as Attachment 1 at the end of this document. The interview questions are included as Attachment 2.

We also felt that input by Massachusetts residents was of vital importance to the success of this initiative. For that reason, public forums were conducted on February 25<sup>th</sup> in Lowell, February 26<sup>th</sup> in Holyoke, February 27<sup>th</sup> in Boston, and February 28<sup>th</sup> in Brockton. To facilitate maximum participation by consumers, the meetings in Lowell, Holyoke, and Brockton were conducted in the evening. Approximately 20 people attended the meeting in Lowell, 75 in Holyoke, 125 in Boston, and 35 in Brockton. A number of the attendees testified regarding their problems/issues with the health care system in Massachusetts and their priorities and solutions for its improvement.

The consulting team also developed a survey for distribution to interested consumers; the survey was not intended to be statistically valid. Its purpose was to solicit the opinions of individuals that attended the public forums or could not be interviewed regarding health care issues. Approximately 400 surveys were distributed at the public forums and to other individuals at their request. The survey was also available at the project's website ([www.state.ma.us/healthcareaccess](http://www.state.ma.us/healthcareaccess)). Through May 2002, 178 surveys have been returned.

The remainder of this document discusses the findings of the stakeholder interviews, public forums, and consumer surveys. The project team wishes to convey its thanks to each individual who spoke with us, presented testimony at the public forums, or completed a survey. Their time and thoughtful opinions were much appreciated and will be considered throughout the completion of this project.

### **Stakeholder Interview Findings**

The interview questions contained in Attachment 2 served as a starting point for our discussions with the stakeholders. These questions were developed to guide the interview process and obtain responses on similar issues from the interviewees. Time was allowed in each interview for the stakeholders to discuss any related topics that were not covered during the meeting.

### Consolidated Financing and Streamlined Delivery

In the legislation that established this project, the feasibility of “establishing a system of consolidated health care financing and streamlined health care delivery accessible to every resident of the Commonwealth...” was debated. To begin the discussion, we asked the interviewees to define “consolidated health care financing” and “streamlined health care delivery”. There was no uniform definition described by the respondents. Definitions for consolidated health care financing included:

- Combining all financing sources into a single payer
- A single point of control and oversight
- A fully government financed system that builds on current processes
- A universal system (coverage for all) with multiple payers and providers
- One government agency to ensure consistency of payment
- As few payers as possible
- Consolidated funding that involves both public and private entities

Regarding streamlined health care delivery, opinions included:

- Paperwork reduction
- Elimination of paperwork and multiple systems
- A change in where care is delivered and how it is provided
- One billing system, payment mechanism, and reimbursement amount
- Individuals can go to the closest location for care and all gatekeepers but the individual’s physician are eliminated

### Access to Health Care

Regarding the issue of access to health care services, interviewees discussed health insurance coverage, availability of providers, cost, transportation, cultural competence, and physician office hours. Although Massachusetts has one of the lowest uninsured rates in the nation (According to information compiled by the Division of Health Care Finance & Policy, the uninsured rate in Massachusetts during 2000 was 5.9 percent for all ages, 8.0 percent for individuals between the ages of 19 and 64, and 3.0 percent for persons under 19 years of age.), some interviewees said that coverage needs to be improved for seniors and low income adults, including individuals who are homeless. Another gap in public program coverage that was mentioned was undocumented immigrants.

The State’s coverage of children through Medicaid, SCHIP, and other public programs was praised by most stakeholders. According to one interviewee, in theory there is entitlement to health care for all Massachusetts’ children. However, it was reported that 3.0 percent of the State’s children do not have health insurance coverage. This was attributed to a lack of knowledge of

available programs or children whose family income required a premium, but the family perhaps could not afford to pay that premium.

Other interviewees stated that having coverage is no guarantee of care. A large percentage of dentists, radiologists, anesthesiologists, and dermatologists (particularly in Western Massachusetts) will not see Medicaid patients because of low reimbursement rates. Obtaining dental care on Cape Cod, Martha's Vineyard, and Nantucket was also reported to be a problem. Most interviewees agreed that behavioral health services were difficult for State residents to obtain. Critical service shortages were reported in long-term residential treatment and supported living for children and adults, community-based programs, and social supports (including rental subsidies). Although there are twice the number of mental health practitioners per capita in Massachusetts than other states, it was reported that many will only accept private pay patients.

Interview subjects also reported a shortage of nursing facility beds for residents in need of long term care services. Since 1980, we were told that 5,000 nursing home beds have been lost because of facility closures or mergers.

Other access issues included an inability to get to providers because of a lack of transportation or inconvenient office hours. Since 6.7 percent of Massachusetts households reported during the 2000 Census that they do not speak English "very well", language and other cultural competency issues were also reported as barriers to care.

Emergency room (ER) diversion is a growing problem at Massachusetts' hospitals, particularly in the Boston area. Although this issue is complex and outside the scope of our project, stakeholders attributed part of the problem to use of the ER for non-emergency care, an inability to move ER patients to inpatient beds because beds are filled with patients waiting for residential behavioral health care, and the unavailability of sufficient nursing staff.

Affordability of health insurance and services is also becoming a critical issue for Massachusetts' employers and residents. Employers, both large and small, reported premium increases of 15 to 20 percent over the previous year. Costs are being passed on to employees via increased premiums or cost-sharing, or benefit reductions. Paying for prescription drugs is increasingly problematic for individuals, particularly senior citizens and the disabled with no or limited prescription drug coverage.

### Strengths/Weaknesses of System

To ensure that the strengths of the Massachusetts health care system are retained in our proposed options, we asked interviewees to discuss the strengths and weaknesses of Massachusetts' delivery system. The strengths that were described included:

- Quality teaching hospitals
- Excellent delivery system, quality of care, and health care professionals
- Good distribution and diversity of providers
- Political leaders that support health care programs
- Innovative Medicaid program with generous benefit package
- Unique public programs (Insurance Partnership and Free Care Pool)
- Strong health care advocates
- Strong network of community health centers and community based providers
- Extensive citizen support for health care initiatives
- Good health plans with high accreditation and strong customer service
- Tremendous health care resources, including knowledgeable academics
- Large employer participation in health care

As might be expected, certain of the strengths described above created some of the weaknesses or issues described by the individuals we interviewed. The weaknesses included:

- Large health care premium increases caused by medical inflation, prescription drug costs, an aging population, and cost-shifting from Medicare and Medicaid
- Lack of coverage for all residents
- The numerous insurance mandates required by the Legislature
- Overly generous Medicaid benefit package
- Lack of consumer knowledge of health care costs
- Most expensive health care system in world; health care costs are 2<sup>nd</sup> or 3<sup>rd</sup> in nation among peer states
- Poor reimbursement of all health care providers
- Insufficient inpatient mental health beds for adults and children
- Insufficient mental health programs at community level, and insufficient number of providers
- Under-funded mental health care programs
- Too many public programs with complex eligibility requirements
- Hospital based delivery system, which produces high costs
- Lack of health insurance coverage for health care workers
- High health care worker turnover
- Shortage of nurses, pharmacists, and radiology technicians, coders, billers, and medical records staff
- Too many health care reporting requirements
- Lack of a well organized system of care
- Absence of prevention and chronic care in physician training
- Administrative burden and paperwork duplication
- Insufficient number of hospital beds and ER capabilities

- Limited availability of home care
- Excess use of tertiary hospitals and insufficient use of community hospitals
- Increased hospital acuity and reduced nursing ratios
- Shifting of health insurance/care costs from insurers/employers to individuals
- Poor allocation of health care resources across the State
- Poor service availability for the homeless and immigrants

### Barriers to Consolidation and Streamlining

The LECG team asked the interviewees what barriers exist to the establishment of a consolidated health care financing and streamlined health care delivery system. Whether or not the stakeholder favored a single payer system, the issue explored by this question is potential barriers to significant change. The barriers that were identified included:

- Time constraints – can not move from the status quo to a single payer system in a reasonable amount of time
- Resistance to and fear of change by involved parties (including Legislature)
- Lack of financial resources
- Multiple IT systems and administrative requirements
- Private sector profit issues
- Lack of trust in a government sponsored program
- Difficulty implementing a single payer system in a single State (versus a national approach)
- Barriers to including Medicare in any consolidation plan
- Disbelief that a single payer system will work and concern regarding its cost
- Traditions of insurers and providers
- Lack of agreement on approach and oversight process(es)

### A “Perfect” Health Care System

So that we could identify the gap between Massachusetts’ current health care delivery system and future options, we asked the interviewees to describe the “perfect” health care program. Subsequent to posing that question, we asked the interviewees to select a single initiative to fund, given that resources are limited. The majority of respondents stated that the most important issue is access. They were clear that all Massachusetts’ residents should have access to affordable health care coverage, including mental health services.

Affordability was also of major importance to employer groups and other advocates. At the present time, more and more employers are dropping health insurance coverage or passing costs on to employees because of premium

increases. Other most important improvements suggested by the interviewees included:

- Increase the availability of mental health services
- Develop governmental agency staffed by medical personnel and consumers to oversee the health care delivery system

Because of the number of improvements that the interviewees suggested, we have summarized them into seven categories. These categories are:

1. Social contract issues
2. Consolidation strategy
3. Benefit package
4. Financial issues
5. Consumer education and quality
6. Implementation process
7. Other

### Social Contract Issues

This section of the “perfect world” discussion presents the opinions of the interviewees regarding the responsibilities and rights of the Commonwealth and its citizens regarding health care.

- The health care system needs to be maximally just. Money must be spent well, but health care must be available to all. Everyone should have the right to adequate, efficient, quality health care, and be free to choose providers. The system must be accountable and responsive.
- Health care must be a right, not a commodity.
- Health care must be available, accessible, affordable, and suitable.
- Every State resident should have coverage as comprehensive as State employees.
- Every State resident should be required to have health coverage; financial assistance should be available if necessary. Covering everyone is not only a social good, it is an economic good.
- One solution is to decide that health care is an entitlement for all, and move there incrementally.
- Collegiality must be added to the health care system. All stakeholders must work together to achieve a solution.
- There should be an affordable insurance product for all, with sliding fee schedules.
- There should not be an individual mandate; purchasing coverage is an individual decision.

## Consolidation Strategy

A number of stakeholders supported a single payer system, while others were in favor of an all payer system that reimbursed providers according to rates set by a State agency. Other consolidation comments included:

- The single state agency would not only determine the health care budget and reimbursement, it would also determine where providers are needed and reimburse them accordingly.
- Under a consolidated system, all payers should pay the same way on the same terms. There must be common definitions and structures around billing.
- Utilize an incremental approach, by first increasing the Medicaid asset limit. Employers should have an incentive to not reduce or eliminate health insurance benefits.
- Combine all state programs into one and allow individuals to buy into the program.
- The perfect system should build on what already exists. It may be helpful to create a public/private partnership that establishes other buy-in options (such as the GIC).
- Look at Free Care Pool (FCP) spending in certain areas of the State. It may be cost effective in Lawrence, Lowell, or Springfield to purchase coverage for the uninsured through the GIC.
- Administrative simplification should include intake, medical records, billing, formularies, claims processing, credentialing, and reporting.
- Would like to see a catastrophic plan with medical spending accounts. Individuals would be responsible for the cost of a basic benefit package. There would still be a government role for low-income citizens, but they would have cost sharing responsibilities.
- A short-term strategy is to expand public programs as far as possible, and then work on quality and bulk purchasing.
- Include the underinsured in the FCP with a sliding fee schedule. The uninsured should be allowed to buy into the FCP.
- Consider a two to three year lock in for Medicaid to protect the FCP.
- Care must be delivered in the most appropriate site. Hospitals should work with community health centers (CHCs) to build capacity at the CHCs.
- Long-term care services are costly. Either this part of Medicaid should be federalized or a Medicare Part C should be created to cover long term care services.
- If the FCP, Mass Health, the DET plan for the uninsured, and the Medicaid/Medicare waiver are utilized to their fullest capability, almost everyone in the State would be covered.
- There must be recognition (and incentives) that community hospitals provide the most services and do it most efficiently.
- Health care insurance should cover catastrophic and preventive care.

- Programs to cover the uninsured and underinsured must be streamlined. Medicare plus prescription drugs is a good program model. Develop a pilot program that combines Medicaid, Medicare, and the uninsured into a single program with single reimbursement and eligibility systems.

## Benefit Package

The interviewees' thoughts on the "perfect" benefit package varied from catastrophic coverage to coverage of everything that the individual's physician determined was medically necessary. The thoughts we heard included:

- The benefit package should include all medically necessary services. There is no need for care rationing.
- Universal coverage requires baseline benefits; primary and preventive care must be part of the baseline.
- A perfect system should include unlimited choice of providers and allow the integration of new therapies. It should also provide disease management and preventive care, and offer tiered benefit choices.
- A standardized benefit package should be based on the Medicaid or State employees' programs.
- Children need more home, school-based, and wraparound services.
- The benefit package must be comprehensive and include mental health services, public health care, preventive, acute, and chronic care.
- Public programs are currently either categorical or disease oriented. They must be coordinated or integrated.
- There should be sliding copayments and deductibles, even for Medicaid eligibles at the higher income levels. There should be cost sharing for network/out of network usage.
- Medicare is a good benefit package, but better coverage is needed for long-term care services and prescription drugs.
- There should be no copayments; they discourage people from obtaining care.
- Certain mandates must be eliminated. These include in-vitro fertilization, chiropractic care, and genetic screening. The periodicity of preventive care must be reviewed and tightened by medical experts, preferably at the national level.
- If limits are necessary, premiums and copayments should be adjusted before benefit packages.
- Any benefit package decision must address inappropriate use of the emergency room and the overprescribing of drugs to senior citizens.
- There must be enough home care, so people can choose to remain at home.
- Care must be designed around the patient, and emphasize case management and patient education.

- We need to return to the basic preventive care model. Health care should cover medical/surgical benefits and basic rehabilitation. Preventive care should be an individual responsibility.
- We need to mobilize social resources for care delivery, and invest capital in innovative solutions, such as time banking and service credits.
- The perfect solution would include a baseline level of health care (preventive and primary care, dental and mental health services) for all, with people paying based on their income.
- CHCs should have the capability to provide oral health.
- People should be able to choose their primary care physician, even if it is a specialist or a physician extender. They should have access to any or all providers. Preventive care should be incentivized.
- There must be full integration of physical and mental health care, so individuals can see mental health providers as necessary.
- Health care policy makers need to look at the feasibility of allowing health plans to provide a bare bones product without mandates or other statutory requirements.

## Financial Issues

Opinions regarding the financing of health care ranged from individual income taxes to improvement of the status quo. Several stakeholders favored the imposition of a \$.50 per package tobacco tax and elimination of planned tax cuts. There were also several suggestions for reducing the cost of health care. The stakeholders said:

- A global budget should be created, managed by one State agency and funded by income taxes. The budget would be based on past years' experience and expectations for the following year.
- Health care should be financed by a tax; a cigarette tax is acceptable.
- The State should institute a nursing home user fee; private pay patients and nursing facilities would pay a \$10 per day fee. This could then be federally matched for Medicaid recipients who reside in a facility.
- The State should increase the tobacco tax to expand Mass Health coverage to 19 and 20 year olds, parents of SCHIP children, and other gap individuals.
- Funds from the tobacco settlement should be used for health care improvements.
- The State should not institute the capital gains cut and should eliminate the State tax rollback.
- The FCP is a program worth strengthening.
- The health care tax subsidy for businesses needs to be extended to the self-employed.

- Health care should be funded like Social Security; the employer and the employee contribute. There should be a separate rate for the self-employed.
- There needs to be a distinction made between universal access and single payer. Single payer advocates have not looked at implementation costs.
- A single payer system could be financed through the elimination of corporate income tax.
- There is enough money in the health care system to provide good care for all.
- Employers should contribute to a health care fund, but they should not be involved in their employees' health care. The health care fund should be supported by a per capita, means adjusted tax.
- Health care should be funded by cigarette and gasoline taxes.
- Funding should come from an employer tax, employee premiums, and a sliding fee schedule.
- Patients need to be moved away from high cost teaching hospitals to lower cost options.
- Pharmacy costs must be controlled with formularies and bulk purchasing.
- The Legislature should pass the reusable medication legislation.
- The primary care system must be supported and advertised. Community health centers should be incented to develop networks beyond primary care.
- No further insurance mandates should be implemented without serious cost benefit analyses attached. Given the associated costs, are all mandates in the consumers' best interest?
- The State should use public money for a public system. The private sector should not be shored up with public funds.
- The State must determine what is a legitimate cost, especially for hospitals.
- Teaching hospitals must downsize programs, focus on clinical quality, deliver what they do well, and determine the best method to deliver it.
- There must be financial recognition that community hospitals provide the most services and do it most efficiently.
- We must look at drug profits and accept a certain level. Prices need to be lowered and drugs need to be government purchased for those that can not afford them. Money used on drug detailing and marketing should be used for research. If there were price controls on name brand drugs, generics would not be necessary.

### Consumer Education and Quality

The stakeholders we interviewed expressed the need for significant consumer education regarding healthy lifestyles, the appropriate use of health care services, and the quality of provided care. Some interviewees thought that the

Department of Public Health should be much more involved in these initiatives than it is currently. Other opinions included:

- There needs to be optimal health initiatives and increased emphasis on disease management.
- Outreach is vital to ensure that all citizens eligible for public programs are enrolled in them. Consumers must also be educated to use services appropriately.
- Nursing schools and other health care training facilities must be assisted so that capacity can be built.
- The appropriate level of care must be provided in the appropriate setting for the appropriate period of time.
- Teaching hospitals need to create community hospital settings within themselves, so that they can deliver good primary care at a reasonable cost.
- All State residents should have access to information about provider quality and outcomes.
- Health care programs must be simple, so they can be communicated clearly. This includes the Insurance Partnership Program.
- The State's Division of Insurance and the Attorney General's office do a great job monitoring insurers, health plans, and providers. Further regulation is not necessary.
- The health care system should be based on retrospective review, not prior approval. There needs to be a clear grievance process.

### Implementation Process

When asked about how health care improvements could be implemented, the stakeholders had the following suggestions:

- If there is a law to mandate universal health care, a single entity must guide the implementation process.
- A consolidated system could start with government covered individuals, then move to people covered by their employers.
- As a first step, the Medicaid asset limit should be raised.
- Change should be phased in via pilot projects and involve stakeholders. Citizens need to overcome their resistance to change.
- The public and private sectors should join with the Heinz Foundation to create a single payer drug program.
- A single eligibility system should be developed that would screen individuals for all public programs and transmit the necessary information to the appropriate State agency.
- State policy makers must streamline eligibility and try to reach a seamless system.
- The Mass Health structure should be used to create a long range plan for additional coverage.

- The public sector (Medicaid and the GIC) needs to increase its use of the Internet and information technology to allow business transactions, such as claims processing, with the health plans.

#### Other

This final group of suggestions does not fit into any of the previous categories. However, we thought they should be included in this document because of their importance to the stakeholders.

- If everyone had health care coverage, citizens would be easier to track. This could be an aid in terrorism prevention/detection.
- There should be a quasi-public authority to provide health care coverage for public workers. Nurses and home health care workers could work for the “quasi” agency and be able to be covered by the State’s health care coverage.
- Eligibility requirements for Mass Health must be changed for certain parts of the State with excessive costs of living.
- CHCs and hospitals have staffing issues that must be addressed. Shortages include dentists, nurses, pharmacists, radiology technicians, coders/billers, and medical records personnel. There needs to be loans and other incentives to support recruitment and training programs.
- In the past, public health nurses delivered services to children. Perhaps this should be considered again.
- The State uses its research needs to affect the billing process. It usually pays claims in 90-180 days. There should be payment timeframe requirements.
- Homelessness should be an acceptable category for Medicaid eligibility.
- Training and research should be funded separately, so that public programs are not required to support these activities.

#### Public Forum Findings

As mentioned in the introduction to this document, citizen involvement is of vital importance to the completion of this project. In fact, inclusion of the public forums in our proposal was one of the reasons that LECG was selected by the Advisory Committee to complete this initiative.

At the recommendation of the Advisory Committee, we conducted public forums in Lowell, Holyoke, Boston, and Brockton. These forums were conducted on February 25-28, 2002, respectively. With the exception of the Boston forum, the meetings were held in the evening to ensure maximum participation. Approximately 20 people attended the meeting in Lowell, 75 in Holyoke, 125 in Boston, and 35 in Brockton. The majority of the attendees and speakers were

advocates of a single payer system. The balance of this section will summarize the issues that were raised during the four public meetings.

Most of the presenters were in favor of a single payer system because of problems they or their constituents (clients, patients, etc.) were experiencing with the health care system. These problems included cost, accessibility, quality, and administrative complexity:

### Cost

- Cost of prescription drugs
- Significant health insurance premium increases
- Increases in deductibles/copayments or benefit reductions
- Inability of health care workers to afford health insurance
- Coverage unaffordable for small businesses

### Benefits and Accessibility

- Waiting times for physician appointments
- Lack of mental health services
- Lack of good home care options
- Loss of coverage due to business closings
- Inability to reach providers by telephone
- Inadequacy of Prescription Advantage program
- Mass Health dental cuts
- ER diversions
- Coverage waiting periods

### Quality of Care

- Episodic care

### Administrative Complexity

- Excessive administrative burdens on providers
- Medical documentation duplication
- Excess data collection requirements by State

### Other

- Excessive occupational injuries for health care workers

Most of the individuals who testified during the public forums favored a single payer solution to the issues identified above. These individuals wanted a health care system that:

- Provides health care coverage for all Massachusetts citizens
- Covers all medically necessary services, includes preventive, dental, and mental health care and prescription drugs
- Has no deductibles or copayments
- Has no limitation on choice of provider
- Is administered by a single state agency
- Is funded by a graduated health care tax
- Removes profit from health care
- Reduces amount and duplication of paperwork and other administrative requirements
- Has simplified eligibility
- Keeps current delivery system intact
- Has no waiting periods for coverage
- Requires employer participation

Those speakers that favored a more incremental approach also supported universal access to health care. They were in favor of an additional tobacco tax to fund other Mass Health coverage groups and expansion of the FCP. Another speaker expressed concern over the significant change that would be necessary to implement a single payer system.

### **Consumer Survey Findings**

The consumer survey was not designed or administered to be statistically valid. Its purpose was to solicit the opinions of individuals that attended the public forums or could not be interviewed regarding health care issues. As such, respondents were individuals who cared deeply about the health care system, who were able to attend one of the public forums or receive a survey from a forum attendee.

The survey was meant to gain insight on the availability and cost of health care. It, like the stakeholder interviews and the public forums, was another means of gathering information to guide the economic modeling in later phases of the project.

The survey was available in English and Spanish, and was distributed at the public forums, as requested, and on the website. Of the approximately 400 surveys distributed, as of May 2002, 178 have been returned, for a 45% response rate. A copy of the survey is included as Attachment 3.

### **Source of Health Insurance**

The consumer survey results show that 73% of respondents primarily receive their health insurance through their employer, 10% privately purchase insurance, 11% receive insurance through publicly funded programs such as Medicare, 1% do not have insurance, and the remaining 5% receive insurance from a

combination of employer sponsored, privately purchased, or publicly funded sources.

#### Level of Satisfaction with Access to Health Care Services

When asked about their level of satisfaction with their ability to access health care services, there were varying response numbers depending on the service specified. This seems reasonable since not every respondent would receive long term care services; thus there would be fewer respondents for long term care services than for medical care.

Of respondents, 83% were either “very satisfied” or “satisfied” with their access to *medical care*. Just over half of respondents, 51%, were either “very satisfied” or “satisfied” with access to *mental health services*. However, 65% of respondents were not satisfied with their access to *home health care*, and 72% of respondents were not satisfied with their access to *long term care* services.

#### Number of Times Forced to Change Health Insurance

When asked how often they had to change health insurance companies or plans over the past two years, 55% of respondents did not change coverage, 26% changed coverage once, and 19% changed coverage two or more times. One respondent noted that s/he had not changed because there was no other choice and another changed because his/her employer’s offered coverage changed.

#### Number of Times without Health Insurance

When asked how many times consumers were without health insurance over the past two years, 81% of respondents were never without coverage, 11% were without coverage once during the two-year period, 7% were without insurance two or more times, and 1% did not have insurance during the past two years.

#### Number of Times Forced to Change Providers

When asked how often consumers had to involuntarily change doctors or health care providers, 60% of respondents did not have to change providers, 22% had to change providers once, and 18% had to change providers two or more times. One respondent had to change hospitals because the hospital did not renew its contract with the individual’s existing health plan. Another respondent had three or more forced changes because providers refused to accept HMO coverage.

#### Willingness to Pay for Consolidated Financing and Streamlined Delivery

When considering consolidated health care financing and a streamlined delivery system, 34% of respondents thought that they should pay less than they currently pay, 35% were satisfied with the amount that they currently pay, and

29% were willing to pay more than they currently pay. One respondent indicated that s/he should pay less because there would be less duplication, bureaucracy, marketing costs, and profits. Another said that such a system would be less expensive, making it unnecessary to pay more. Other respondents were willing to pay more if coverage were efficient or quality of care improved.

## **Conclusion**

The purpose of this summary was to convey, as completely and objectively as possible, the opinions and suggestions of the interviewees, forum participants, and survey respondents regarding the state of health care in Massachusetts. Because of the vast amount of information that was collected, not every opinion could be included in this document. However, we have tried to convey the participants' positions in as comprehensive, yet concise, a manner as possible, without making value judgements. During subsequent project phases, we will work with the Advisory Committee to develop workable solutions to these important issues.